Exhibit 8

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Durham Division

VICTOR VOE, *et al.*, *Plaintiffs*, v. THOMAS MANSFIELD, *et al.*, *Defendants*, and PHILIP E. BERGER, *et al.*, *Intervenor-Defendants*.	Civil No. 1:23-CV-864-LCB-LPA

EXPERT REPORT OF DAN H. KARASIC, M.D.

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over 18 years of age, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a Professor Emeritus of Psychiatry at the University of California – San Francisco (UCSF) Weill Institute for Neurosciences. I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

4. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California – Los Angeles (UCLA) Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow at UCLA in a training program in mental health services for persons living with AIDS.

5. For over 30 years, I have worked with patients with gender dysphoria. I am a Distinguished Life Fellow of the American Psychiatric Association and have been the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

6. Over the past 30 years, I have provided care for thousands of transgender patients. For 17 years, I was the psychiatrist for the Dimensions Clinic for transgender youth in San Francisco, which treats trans youth 12-25 years old. I also have provided care for many adolescents in my UCSF faculty practice and my current private practice.

7. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of WPATH's *Standards*

of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Versions 7 and 8, which are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. For Version 8, I was the lead author on the Mental Health chapter.

8. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 2,000 health care providers.

9. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care and co-wrote the mental health section of the original *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* in 2011 and the revision in 2016.

10. I have worked with the San Francisco Department of Public Health, helping to develop and implement their program for the care of transgender patients and conducting mental health assessments for gender-affirming surgery. I served on the City and County of San Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

11. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient

psychiatrist for HIV-AIDS patients at UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of transgender patients, including those with gender dysphoria, and HIV-positive patients. I also regularly provide consultation to psychologists and other psychotherapists working with transgender patients, including those with gender dysphoria. I have been a consultant in transgender care to the California Department of State Hospitals and the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people.

12. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive other medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*, I am, and given the nature of my work must be, familiar with additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

13. In addition to this work, I have done research on the treatment of depression. I have authored many articles and book chapters and edited the book *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation*.

14. Since 2018, I have performed over 120 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

15. My professional background, experiences, publications inclusive of those authored in the past 10 years, and presentations are further detailed in my curriculum vitae ("CV"). A true and correct copy of my CV is attached as **Exhibit A**.

B. Compensation

16. I am being compensated for my work on this matter at a rate of $400.00 per hour for preparation of declarations and expert reports. I will be compensated $3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Previous Testimony

17. Over the past four years, I have given expert testimony by deposition in the following cases: *Boe v. Marshall*, No. 2:22-cv-184-LCB (N.D. Ala.); *Doe v. Ladapo*, No. 4:23-cv-00114 (N.D. Fla.); *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.); *Brandt v. Rutledge*, No. 4:21-cv-00450 (E.D. Ark.); *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145 (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); and *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W. Va.). To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

II. BASES FOR OPINIONS

18. In preparing this declaration, I have relied on my training and my decades of clinical experience as a psychiatrist treating patients with gender dysphoria, including

adolescents, and young adults, as well as my experience conducting research, as set out in my CV (attached hereto as **Exhibit A**), and on the materials listed therein.

19. I have also relied on my knowledge of the peer-reviewed research regarding the treatment of gender dysphoria, which reflects advancements in the field of transgender health. I have reviewed the materials listed in the bibliography attached hereto as **Exhibit B**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report.

20. I have also relied on my knowledge of the clinical practice guidelines for the treatment of gender dysphoria, including my work as a contributing author of the WPATH Standards of Care, Versions 7 and 8, and the UCSF Guidelines.

21. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

22. In addition, I have reviewed the Amended Complaint in this case; North Carolina House Bill 808 (hereafter, "HB808" or "the Ban"), enacted by the North Carolina legislature and entitled "An Act to Prohibit Gender Transition Procedures for Minors"; the declarations of plaintiffs Vanessa Voe (Dkt. Nos. 14-9 and 45-8) and Jennifer Doe (Dkt.

No. 45-6); the declarations of Dr. Deanna Adkins (Dkt. Nos. 14-2 and 45-3), Dr. Johanna Olson-Kennedy (Dkt. Nos. 14-5 and 45-5), and Dr. Armand Antommaria (Dkt. Nos. 14-3 and 45-4), submitted by Plaintiffs; the declarations of Dr. James Cantor (Dkt. Nos. 37-1, 51-1, and 79), submitted by Defendants, as well as the materials attached as Appendix A to Dr. Cantor's supplemental declaration (Dkt. No. 79-1); and the transcript of the December 12, 2023 deposition of Dr. Adkins.

23. I also rely upon my interview of Victor Voe and his parents on May 17, 2024, my interview of Joy Doe and her parents on May 21, 2024, and my review of the mental health and medical records for Victor Voe and Joy Doe.

III. SUMMARY OF OPINIONS

24. The Ban prohibits medical treatments that are part of widely accepted medical protocols for the treatment of adolescents with gender dysphoria. The following medical groups, among others, recognize that gender-affirming health care is safe and effective for adolescents: American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the American Psychological Association, the American Psychiatric Association, and the American Medical Association, among many other mainstream medical organizations.

25. The accepted protocols for the treatment of adolescents with gender dysphoria provide for careful mental health assessments, including of co-occurring conditions; stringent criteria for eligibility for each treatment; and a thorough informed

consent process with the adolescent and their parents, before any medical interventions are initiated.

26. Decades of medical research and clinical experience have demonstrated that the banned medical treatments are safe, effective, and medically necessary to relieve gender dysphoria for many adolescents.

27. I have seen first-hand, countless times over decades of practice, the many benefits of this treatment. Denying gender-affirming medical care to adolescents for whom it is medically indicated puts them at risk of significant harm to their health and well-being, including heightened risk of depression and suicidality.

28. For adolescents for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.

IV. EXPERT OPINIONS

A. Gender Identity

29. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia.

30. While the terms "male sex" and "female sex" are sometimes used in reference to a person's genitals, chromosomes, and hormones, the reality is that sex is complicated and multifactorial. Aside from external genital characteristics, chromosomes, and endogenous hormones, other factors related to sex include gonads, gender identity, and variations in brain structure and function.

31. HB808 defines "biological sex" as "The biological indication of male and female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads, and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender." However, because these factors may not always be in alignment as typically male or typically female, "the terms biological sex and biological male or female are imprecise and should be avoided." (Hembree, et al., 2017).

32. Gender identity is "a person's deeply felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; or an alternative gender." (American Psychological Association, 2015, at 834). Everyone has a gender identity. Gender identity does not always align with a person's sex assigned at birth.

33. Gender identity, which has biological bases, is not a product of external influence and not subject to voluntary change.

34. For most people, their sex assigned at birth, or assigned sex, matches their gender identity. For transgender people, their assigned sex does not align with their gender identity.

35. Based on data from the Williams Institute, approximately 0.6% of the United States population age 13 or older, or about 1.6 million people, identify as transgender. In North Carolina, the Williams Institute estimates that around 8,500 people aged 13-17 are transgender and approximately 71,300 adults age 18 or older are transgender. (Herman, et al., 2022).

36. Being transgender is widely accepted as a normal variation in human development. Simply being transgender or gender nonconforming is not a medical condition to be treated and is not considered a mental illness. People who are transgender have no impairment in their ability to be productive, contributing members of society simply because of their transgender status.

37. For example, the DSM-5 unequivocally repudiated the outdated view that being transgender is a pathology by revising the diagnostic criteria (and name) of gender dysphoria to recognize the clinical distress as the focus of the treatment, not the patient's transgender status, noting that diagnosis and treatment are "focus[ed] on dysphoria as the clinical problem, not identity per se." (DSM-5, at 451).

38. Similarly, WPATH's Standards of Care, Version 8 states: "The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. … It should be recognized gender diversity is common to all human beings and is not pathological. However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions." (Coleman, et al. 2022).

39. The American Psychological Association states: "Whereas diversity in gender identity and expression is part of the human experience and transgender and gender nonbinary identities and expressions are healthy, incongruence between one's sex and

gender is neither pathological nor a mental health disorder." (American Psychological Association, 2021).

40. Accordingly, and as documented by multiple leading medical authorities, efforts to change a person's gender identity are ineffective, can cause harm, and are unethical. (American Psychological Association, 2021; Byne, et al., 2018; Coleman, et al., 2022).

B. Gender Dysphoria

41. The term "gender dysphoria" refers to the distress related to the incongruence between one's gender identity and attributes related to one's sex assigned at birth.

42. The diagnosis of Gender Dysphoria (capitalized) is a serious medical condition, and it is codified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) (DSM-5 released in 2013 and DSM-5-TR released in 2022).

43. "Gender Dysphoria in Children" is a diagnosis applied only to pre-pubertal children. The criteria for this diagnosis are:

> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following (one of which must be Criterion A1):
>
> 1. A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one's assigned gender)
>
> 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.

3. A strong preference for cross-gender roles in make-believe play or fantasy play.

4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

5. A strong preference for playmates of the other gender.

6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

7. A strong dislike of one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social circles, school, or other important areas of functioning.

44. The DSM-5-TR has a separate diagnosis of "Gender Dysphoria in Adolescents and Adults," which involves two major diagnostic criteria. The criteria are:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics.

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

45. Gender dysphoria is a condition that is highly amenable to treatment, and the prevailing treatment for it is highly effective.

46. When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, and suicidality. This is noted both in adults and adolescents. These risks decline when transgender individuals are supported and live according to their gender identity.

47. With access to medically indicated care, transgender people can experience significant and potentially complete relief from their symptoms of gender dysphoria. Not only is this documented in scientific literature and published data, but I witness this each time I see my patients being supported by their community, family, school, and medical providers.

C. Evidence-Based Guidelines for Treatment of Gender Dysphoria

48. The World Professional Association of Transgender Health (WPATH) has issued *Standards of Care for the Health of Transgender and Gender Diverse People* ("WPATH SOC") since 1979. The current version, published in 2022, is WPATH SOC 8. The SOC 8 provides guidelines for multidisciplinary care of transgender individuals,

including children and adolescents, and describes criteria for medical interventions to treat gender dysphoria, including puberty-delaying medications, hormone treatment, and surgery when medically indicated.

49. The SOC 8 is based upon a more rigorous and methodological evidence-based approach than previous versions. (Coleman, et al., 2022). The process of developing the WPATH Standards of Care, Version 8 was a multistep, several years long effort that started in 2017. This process is outlined in great detail in Appendix A to SOC 8.

50. This "process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and the World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process." (Coleman, et al., 2022, at S247 (citing Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice, 2011; World Health Organization, 2019)). And "[t]he SOC-8 revision committee was multidisciplinary and consisted of subject matter experts, health care professionals, researchers and stakeholders with diverse perspectives and geographic representation." (Coleman, et al., 2022, at S247).

51. WPATH SOC 8's evidence-based recommendations were drafted "based on the results of the systematic, and background literature reviews plus consensus-based expert opinions." (Coleman, et al., 2022, at S250). The recommendations were developed and are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and

country settings. A consensus of the final recommendations was attained using the Delphi process that included all members of the Standards of Care Revision committee, and supportive and explanatory text of the evidence for the statements was written.

52. The Delphi process is a procedure by which a panel of experts are asked for their opinion on a relevant issue, summarizing and presenting their collective responses and repeating this process for a certain number of rounds. (Shang, 2023; Hsu and Sanford, 2019). It is "a well-established approach to answering a research question through the identification of a consensus view across subject experts." (Barrett and Healey, 2020).

53. The recommendations submitted to a vote under the Delphi process required approval of 75% of the authors of SOC 8 as a whole. More specifically, for a recommendation to be approved, a minimum of 75% of the voters had to approve the statement. (Coleman, et al., 2022, at S250). With regards to SOC 8, every member of the SOC revision committee voted for each statement. Following the aforementioned process, every recommendation contained in SOC 8, as published in 2022, was approved by 75% or more of the revision committee.

54. The evidence base supporting the recommendations in the WPATH Standards of Care is thus comparable to the evidence base supporting treatment for other conditions.

55. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guidelines) provides similar protocols for the medically necessary treatment of gender dysphoria. (Hembree, et al., 2017).

56. Guidelines from other organizations, including those developed by the UCSF Center of Excellence for Transgender Care, also list similar protocols for the medically necessary treatment of gender dysphoria.

57. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

58. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guidelines are cited as authoritative by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others. They are also relied upon by clinicians treating patients with gender dysphoria.

59. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, posttraumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

60. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.

61. Major medical organizations, such as the American Medical Association, American Psychiatric Association, the Endocrine Society, American College of Obstetricians and Gynecologists, and American Academy of Family Physicians oppose the denial of this medically necessary care and support public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. (American Psychological Association, 2024; American Medical Association, 2023; American Medical Association and GLMA, 2019; American College of Obstetricians and Gynecologists, 2021; American Psychiatric Association, 2020; Endocrine Society, 2020; American Academy of Family Physicians, 2020).

D. Assessment and Treatment of Gender Dysphoria

62. The WPATH SOC 8 and the Endocrine Society Guidelines establish authoritative protocols for the treatment of gender dysphoria.

63. In accordance with the WPATH SOC 8 and the Endocrine Society Guidelines, medical interventions to treat gender dysphoria may include treatment with pubertal suppression and/or hormones, and treatment with surgery, based on a patient's individual needs.

64. For minor patients, all treatment decisions are made in consultation with the patient and the patient's parents or guardian. Consent for medical intervention is provided by the parent or legal guardian in the case of any minor receiving treatment.

65. No medical or surgical treatment for gender dysphoria is provided to pre-pubertal children. For pre-pubertal children, interventions are directed at supporting the child with family, peers, and at school, as well as supportive individual psychotherapy for the child as needed.

66. Adolescents (which generally refers to minors after the onset of puberty) with gender dysphoria may be treated with medications to delay pubertal changes in the early stages of puberty if they are causing distress. Pubertal blocking, which involves methods of temporarily suppressing endogenous puberty, allow the adolescent time to better understand their gender identity, while delaying distress from the development of secondary sex characteristics such as breasts or facial hair. These blockers are reversible medications and once stopped, a patient returns to the stage of pubertal development that had begun when the treatment was initiated.

67. After ongoing work with mental health professionals and when the adolescent has lived in accordance with their gender identity for a significant period of time, they may start treatment with hormones (testosterone for transgender boys, estrogen and testosterone suppressants for transgender girls) if and when medically indicated. The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to their gender identity. For adolescents, this treatment allows patients to have pubertal changes and development consistent with their gender identity. Gender-affirming hormone therapy is a partially reversible treatment in that some of the effects produced by the

hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice, decreased testicular mass).

68. Under the WPATH Standards of Care, puberty-delaying medication for transgender adolescents after the beginning of puberty and gender-affirming hormone therapy for older adolescents may be medically indicated if the following criteria are met: (a) Gender diversity/incongruence is marked and sustained over time; (b) Meets the diagnostic criteria of Gender Dysphoria; (c) Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; (d) Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed sufficiently so that gender-affirming medical treatment can be provided optimally; (e) Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.

69. According to WPATH SOC 8, "Chest masculinization surgery can be considered in minors when clinically and developmentally appropriate as determined by a multidisciplinary team experienced in adolescent and gender development" (Coleman, et al. 2022).

70. Affirming care for transgender youth does not mean steering them in any particular direction, but rather supporting them through their period of exploration of gender expression and increasing self-awareness of their identity. (Coleman, et al., 2012, at 18l; Ehrensaft, 2017). WPATH SOC 8 states, "We recommend health professionals working with gender diverse adolescents facilitate the exploration and expression of gender

openly and respectfully so that no one particular identity is favored." (Coleman, et al., 2022). WPATH SOC 8 states "For some youth, obtaining gender-affirming medical care is important while for others these steps might not be necessary." (Coleman, et al., 2022).

71. In my clinical experience, some adolescent patients have a critical need for medical interventions at or at some point after the onset of puberty and others do not. As with all medical interventions, it is highly individualized and responsive to the particular medical and mental health needs of each patient.

72. The WPATH SOC 8 and the Endocrine Society Guidelines further provide that before any medical or surgical interventions are provided to adolescents, a careful mental health assessment should be conducted to ascertain whether the diagnostic criteria for Gender Dysphoria in Adolescents and Adults are met, and the appropriateness of such care for the patient.

73. WPATH SOC 8 recommends that health care professionals working with transgender and non-binary adolescents be licensed, hold a postgraduate degree in a relevant clinical field, have received training and developed expertise in working with children and adolescents, including those with autism spectrum disorder, and have received training and developed expertise in gender identity and diversity in youth, and in assessing the ability of youth to assent/consent to care (Coleman, et al., 2022).

74. The SOC 8 further recommends a "comprehensive biopsychosocial assessment" for adolescents "prior to any medically necessary medical or surgical intervention" for gender dysphoria. The assessment should include gender identity

development, social development and support, diagnostic assessment of co-occurring mental health or developmental concerns, and capacity for decision-making (Coleman, et al., 2022). Such comprehensive assessment is a critical element of providing care before any medically necessary medical or surgical intervention for adolescents with gender dysphoria.

75. The SOC 8 also highlights the importance of involving parent(s)/guardian(s) in the assessment and treatment process for minors, as well as the ability of the mental health professional to distinguish between Gender Dysphoria and other mental health conditions or developmental anxieties (Coleman, et al., 2022).

76. Before gender affirming care is provided, WPATH SOC 8 recommends that impacts of care on fertility, and fertility preservation options be discussed thoroughly with the patient, and in the case of a minor, with parents or guardians.

77. Similarly, the Endocrine Society Guidelines state that only "[mental health professionals] who ha[ve] training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis," which usually includes "a complete psychodiagnostic assessment." (Hembree, et al., 2017, at 3877). It further provides that because gender dysphoria "may be accompanied with psychological or psychiatric problems" it is necessary that clinicians involved in diagnosis and psychosocial assessment meet specific competency requirements and that they undertake or refer for appropriate psychological or psychiatric treatment. *Id.*, at 3876. And "in cases in which severe psychopathology" "interfere[s] with diagnostic work or make[s]

satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues." *Id*.

78. Accordingly, gender-affirming medical interventions are prescribed and provided only after a comprehensive psychosocial assessment by a qualified mental health professional who (i) assesses for the diagnosis of gender dysphoria and any other co-occurring diagnoses, (ii) ensures the child can assent and the parents/guardians can consent to the relevant intervention after a thorough review of the risks, benefits and alternatives of the intervention, and (iii) if co-occurring mental health conditions are present, that they do not interfere with the accuracy of the diagnosis of gender dysphoria or impair the ability of the adolescent to assent to care (Coleman, et al., 2022; Hembree, et al., 2017).

79. As with all medical care, the care provided to transgender young people with gender dysphoria is tailored to the unique needs of each patient based on their individual experiences, proximity to specialists, and general health, as well as the clinical experience of practitioners.

80. The treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions. Indeed, these or similar procedures are provided for cisgender people with other diagnoses.

E. Gender-Affirming Medical Care for Adolescents Is Safe and Effective.

81. There is substantial evidence that gender-affirming medical care is effective in treating gender dysphoria. This evidence includes scientific studies assessing mental

health outcomes for transgender people who are treated with these interventions, including adolescents, and decades of clinical experience.

82. The research and studies supporting the necessity, safety, and effectiveness of medical and surgical care for gender dysphoria are the same type of evidence-based data that the medical community routinely relies upon when treating other medical conditions.

83. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health. (Aldridge et al., 2021; Almazan, et al., 2021; Baker et al., 2021; Murad, et al., 2010; Nobili et al., 2018; Pfafflin & Junge, 1998; T'Sjoen et al. 2019; van de Grift et al., 2018; White Hughto and Reisner, 2016; Wierckx et al., 2014; Cornell, What We Know, 2018).

84. The studies on gender-affirming medical care for adolescents with gender dysphoria (see, e.g., Chen, et al., 2023; Tordoff, et al., 2022; Mehringer, et al., 2021; Kuper, et al., 2020; Olson-Kennedy, et al., 2018; de Vries, et al., 2014; de Vries, et al., 2011) are consistent with decades of clinical experience of mental health providers across the U.S. and around the world.

85. At professional conferences and other settings in which I interact with colleagues, clinicians I meet report that gender-affirming medical care, for those for whom it is indicated, provides great clinical benefit.

86. In my over 30 years of clinical experience treating gender dysphoric patients, including more than 20 years working with adolescents, I have seen the benefits of gender-

affirming medical care on my patients' health and well-being. I have seen many patients show improvement in mental health, as well as in performance in school, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender-affirming medical care.

87. Accordingly, treatments for gender dysphoria are not considered elective or cosmetic. Indeed, as WPATH states, "The medical procedures attendant to gender-affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense but are understood to be medically necessary for the treatment of the diagnosed condition." (WPATH, 2016).

88. Claims that the risks outweigh the benefits of medical treatment are without foundation. The benefits of medical treatment, and risks of withholding care, for transgender youth with gender dysphoria are clear, as described and referenced above.

89. In addition, a treating doctor will not offer gender-affirming medical treatments unless they have concluded after weighing the risks and benefits of care that treatment is appropriate. The risks and benefits of care are discussed with the minor's parents, who must consent to treatment, and to the youth, who must assent. This process is no different than the informed consent process for other treatments. However, for gender-affirming medical care, there may be the additional safeguard of the assessment by a mental health professional, who, in addition to diagnosing gender dysphoria, also assesses a

patient's capacity to assent to treatment and ability to understand the risks and benefits of treatment.

90. In addition, regret among those who are treated with gender-affirming medical care is rare. For example, in one study in the Netherlands, none of the youth who received puberty-delaying treatment, hormones, and surgery, and were followed over an 8-year period, expressed regret. (DeVries, 2014.)

91. Zucker, et al., (2010), summarizing key studies on outcomes for adolescents referred for surgery when they reached the age of majority in the Netherlands, states, "there was virtually no evidence of regret, suggesting that the intervention was effective."

92. Similarly, Cavve et al. (2024) examined the outcomes of 548 of the 552 youth referred to the pediatric gender clinic in Perth, Australia. This study is exceptional in medical literature generally for the extremely high share of former patients the researchers were able to reach. Of 196 youth who were started on puberty blockers or hormones, only 2 (1.0%) discontinued medical treatment because of reidentification with birth sex.

93. These findings about regret being very rare are consistent with my observations in decades of clinical practice.

94. Regret rates for gender-affirming surgery in older adolescents and adults are also very low. (Thornton, et al., 2024). For example, a study of 209 gender-affirming mastectomies in transmasculine adolescents aged 12-17, performed at Kaiser Permanente Northern California from 2013 to 2020, showed a regret rate of 1%. (Tang, et al 2022). A recent study found very high satisfaction and very little regret among those receiving

gender-affirming mastectomy at one U.S. center following a longitudinal period ranging from 2 to 30 years. (Bruce, et al 2023). And a pooled review across multiple studies of 7,928 patients receiving gender-affirming surgery showed a regret rate of 1%. (Bustos, et al., 2021). Over 50 years of gender-affirming surgery in Sweden, the regret rate, as measured by legal gender change reversal, was 2%. (Dhejne, et al., 2014). These are very low regret rates for surgery. For example, 47% of women expressed at least some regret after reconstructive breast surgery following mastectomy for breast cancer. (Sheehan, et al., 2008).

95. Gender-affirming medical interventions in accordance with the WPATH SOC 8 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many adolescents with gender dysphoria. (*See*, *e.g.*, the American Psychological Association, 2024 and 2021; American Academy of Pediatrics, 2018 (reaffirmed in 2023); the American Medical Association, 2021; the Pediatric Endocrine Society, 2021; the American College of Obstetricians and Gynecologists, 2021; the Endocrine Society, 2020; the American Academy of Family Physicians, 2020; the American Psychiatric Association, 2018; and WPATH, 2022).

96. For all these reasons, I am aware of no basis in medicine or science for barring the provision of gender-affirming medical care as treatment for adolescents with gender dysphoria.

F. The Ban Is Based on Misperceptions and Misinformation.

97. A few misperceptions or pieces of misinformation have motivated efforts to ban this evidence-based, safe, and effective medical treatment for transgender adolescents.

98. One misperception is that puberty-delaying medications and hormone therapy are experimental because they are not FDA-approved for the specific application of treating Gender Dysphoria. But medications are very commonly prescribed for off-label uses, particularly in the pediatric population. All gender-affirming hormone treatments are approved for treatment of other conditions and have been used to treat those conditions, as well as for gender-affirming care, for many years, supporting their safety and efficacy. The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality states, "[Off-label prescribing] is legal and common. In fact, one in five prescriptions written today are for off-label use."[1]

99. Another is the false claim that for most youth, gender dysphoria will resolve on its own, making medical interventions unnecessary. These claims are inaccurate and are often in reference to a body of literature sometimes referred to as "desistance" studies, that found that many pre-pubertal children diagnosed with "Gender Identity Disorder in Children" (a precursor diagnosis to "Gender Dysphoria in Children" in the DSM-III-R and

[1] See https://www.ahrq.gov/patients-consumers/patient-involvement/off-label-drug-usage.html.

DSM-IV) identified with their sex assigned at birth at a later follow up. Reliance on this research is misplaced for two reasons.

100. First, the diagnostic criteria for "Gender Identity Disorder in Children" were different from the diagnostic criteria for "Gender Dysphoria in Children" in meaningful ways that result in the desistance studies grossly overestimating the rate of desistance. "Gender Identity Disorder in Children" did not require identification with a gender other than the one assigned to the person at birth. A diagnosis could be made solely on the basis of gender atypical behavior, such as a boy who prefers playing with dolls and dress-up. This means that a child could be diagnosed with Gender Identity Disorder without ever having a transgender identity and, therefore, any study that selected subjects based on this diagnosis could include individuals who never had a gender identity that differed from the sex they were assigned at birth.

101. This problem with the diagnosis was remedied with the DSM-5 diagnosis of "Gender Dysphoria in Children," which requires a child to have "a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." Under this updated diagnosis, a child could not be diagnosed based solely on gender atypical behavior without identifying as a different sex than the one assigned at birth. Because the desistance studies were all conducted prior to the DSM-5, a child did not need to have a transgender identity to be included in the study. Additionally, in some studies, the children did not even meet the looser criteria for Gender

Identity Disorder, but were entered in the studies based on parents bringing the youth to the gender clinic.

102. It is not surprising that many children in these studies did not identify as transgender at follow-up as these children were never transgender and never identified with a gender different from their assigned sex at birth. In fact, the cohorts from UCLA and Toronto in those studies were all or largely *prepubertal* boys who engaged in feminine behavior, leading their parents in the 1960's, 1970's and 1980's to bring them to clinical attention before they came out as gay or bisexual.

103. By contrast, the one large modern American study of pre-pubertal children who were using a pronoun other than one that aligned with their sex assigned at birth, found that only 2.5% of them later identified as cisgender. (Olson, et al., 2022). Simply put, these are different populations of gender diverse children with different trajectories.

104. Second, the desistance studies focused only on pre-pubertal children. Whatever conclusions can be drawn from them about the likelihood of persistence of gender dysphoria in pre-pubertal children, which again is uncertain given the diagnostic limitations identified above, data indicates that once youth reach the beginning of puberty and identify as transgender, desistance is rare. (DeVries, et al., 2011; Wiepjies, et al., 2018; Brik, et al., 2020). This data is consistent with clinical experience. In fact, the Amsterdam and Toronto gender centers that published the desistance data on pre-pubertal children referenced above provided medical interventions to youth whose gender dysphoria persisted into adolescence. (Zucker, et al., 2010; DeVries, et al., 2014). No medical treatments are used

prior to adolescence, so the persistence and desistance rates of pre-pubertal children do not inform the decision whether or not to initiate gender affirming medical treatments in adolescents.

105. "Watchful waiting" is an approach that has been described with respect to the care of pre-pubertal children with gender dysphoria. This approach involves a stance that is neither affirming nor rejecting of a child's asserted gender, but generally does not support social transition in pre-pubertal children. "Watchful waiting" does not apply to adolescents or speak to the appropriateness of medical interventions for adolescents with gender dysphoria. Indeed, the Dutch researchers who coined the term "watchful waiting" for pre-pubertal patients provide puberty blockers, then hormones, when medically indicated during adolescence and have published the successful use of this series of treatments. (Ehrensaft, 2017; DeVries, et al., 2014).

106. Another misperception motivating bills like the Ban is that medical treatment for gender dysphoria is not sufficiently supported because some of the evidence cited in support thereof is of "low quality." But this misapprehends the purpose of the GRADE system and how evidence for medical interventions is evaluated. GRADE criteria assign low quality scores to studies not performed by randomized, blinded clinical trials. However, randomly selecting people to receive or not receive gender-affirming medical or surgical interventions is impossible, for practical and ethical reasons.

107. Additionally, the vast majority of medical interventions for all types of care (aside from gender-affirming medical care) are not supported by so-called "high quality"

evidence, and systematic reviews of most medical interventions of all types show low or very low GRADE scores. (Fleming, et al., 2016; Howick, et al., 2020). Indeed, the body of evidence in the scientific and medical literature, as well as the decades of clinical experience with this medical care, demonstrates that gender-affirming medical care is well-established, safe, and effective, and is as robust if not more so than the body of evidence for other medical conditions.

108. Finally, the cost of providing coverage for gender-affirming care is generally very low. Transgender people constitute a small percentage of the overall population, approximately 0.5%. (Crissman, et al., 2017). Furthermore, the fraction of the population receiving clinical care for Gender Dysphoria is smaller. (Zhang, et al., 2020). As a result, one study estimated an average cost of $0.016 cents per member per month to provide gender-affirming care (Padula, et al., 2016). A study by Herman (2013) similarly found low costs to providing health coverage for gender-affirming care. Additionally, when a form of treatment is covered for cisgender people under an insurance plan, it is generally not disproportionately costly to cover the same treatment for transgender people simply because it is provided to treat gender dysphoria.

G. Harms of Denying Gender-Affirming Care

109. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self.

110. The denial of medically indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, posttraumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

111. The prevalence of these mental health conditions is also thought to be a consequence of minority stress, the chronic stress from coping with societal stigma and discrimination because of one's identity, including gender identity and gender expression. (American Medical Association, 2019).

112. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.[2]

113. I have had patients over the years who were unable to access gender-affirming care when it was clinically indicated, including in the years before this care was more widely available, as well as minors who could not access care due to lack of parental consent. In many of these patients, delayed or denied care resulted in increased depression, anxiety, suicidal ideation and self-harm, increased substance use, and a deterioration in school performance. For patients with severe distress due to their gender dysphoria,

[2] To the extent one proposed alternative is psychotherapeutic treatment to encourage identification with a person's assigned sex at birth, the American Psychological Association has stated that such efforts provide no benefit and instead do harm. (APA, 2021). Or if an alternative approach is to treat the worsening dysphoria only with therapy, that has not shown to be effective in any research.

psychotherapeutic approaches did not alleviate this distress absent medical intervention. Some of my patients had years of intensive mental health interventions, including long-term psychotherapy, without relief of gender dysphoria until receiving medical intervention.

114. Accordingly, major medical organizations, such as the American Medical Association, American Psychiatric Association, the Endocrine Society, American College of Obstetricians and Gynecologists, and American Academy of Family Physicians oppose the denial of this medically necessary care and support public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. (American Psychological Association, 2024; American Medical Association, 2021 (reaffirmed 2023); American Psychiatric Association, 2018; Endocrine Society, 2012, American College of Obstetricians and Gynecologists, 2021; American Academy of Family Physicians, 2020). Denial of this appropriate care for transgender adolescents is also opposed by medical professional organizations responsible for the care of youth, including the American Academy of Pediatrics, the Academy of Child and Adolescent Psychiatry, and the Pediatric Endocrine Society. (American Academy of Pediatrics, 2018; American Academy of Child and Adolescent Psychiatry, 2019; The Pediatric Endocrine Society, 2021).

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H. Assessment of Plaintiffs Victor Voe and Joy Doe

115. Section H of this report is designated as **CONFIDENTIAL/ATTORNEY'S EYES ONLY** pursuant to the Protective Order in this matter (Dkt. No. 60).

i. Assessment of Victor Voe

116. Victor Voe is a 10-year-old transgender boy. His sex assigned at birth was female.

117. I examined Victor on 5/17/24 on a 75-minute appointment with Victor and his parents, via Zoom.

118. Victor first started noticing a difference in gender at age 3—saying, "I'm not a girl" After meeting a co-worker of his mother who used they/them pronouns, he asked of his parents, "Can I use they/them pronouns?" in recognition of this gender difference.

119. Victor had an interest in trains and other boys' toys, and was wrestling and playing with boys at age 3-4. In December 2019, in kindergarten, he was only playing with the boys. When he was just under 6 years old, he told his parents, "I'm a boy. I need you to use he/him pronouns." In first grade, he used he/him pronouns. He states it "felt good."

120. Victor and his parents report some distress early in social transition, for example, being really upset when someone used his "dead name." However, he reports feeling happy when he transitioned socially in first grade and when he changed his legal name in 2023.

121. In Fall 2021, he was happy to be back in school in person in second grade as a boy.

122. In 2021, he started seeing a therapist once a month, discussing his gender. Victor continued discussing his gender with his parents. His parents began exploring treatment options.

123. In March 2023, October 2023, and April 2024, he was seen at the Duke Gender Center.

124. In April 2024, Victor had a physical exam, blood draw, and X-ray for bone age – and his physician said he was at Tanner stage 2 and ready for puberty blockers.

125. Victor had noticed earlier in April that his chest felt different. Victor stated about the changes with Tanner Stage 2: "I feel uncomfortable sometimes. It just feels wrong." He felt anxious and irritable about the changes.

126. His parents have noticed since then that he's been "grumpier" and "little things set him off." Victor states "it depends on the day—sometimes it's on my mind a lot, what might happen next."

127. Victor is waiting for a pediatric endocrinology appointment out of state to start puberty blockers. He is happy about the upcoming referral to get treatment that will prevent further breast growth.

128. Victor has no history of psychiatric medications or other treatment.

129. On exam, Victor is articulate and displays maturity for his age. He is able to answer most questions himself, with his parents filling in dates and details. When asked about possible side effects of puberty blockers, he responded, "bone density," indicating that he understands a potential for side effects. His mood is euthymic with no evidence of

psychosis or suicidal thinking. He is able to be forward thinking in recognizing treatment eventually might affect how he forms a family.

130. Victor has capacity to assent, and his parents have a good understanding of risks and benefits of treatment to provide informed consent. Victor has a diagnosis of Gender Dysphoria in Adolescents and Adults. Victor meets the Standards of Care, Version 8 criteria for starting puberty blockers, which are a medically necessary treatment for his Gender Dysphoria.

ii. Assessment of Joy Doe

131. Joy Doe is a 10-year-old transgender girl. Joy was examined with her parents on 5/21/24 for a 75-minute session.

132. Joy was assigned male at birth. At 2 years old Joy was observed by parents to prefer girls' clothes and play. When playing dress up she would choose princess dresses. She preferred the color pink and to play kitchen. Joy would play with girls as well as with her brothers. At 3 years old in preschool Joy would play with boas and dresses, baby dolls, and would play kitchen and play house. When Joy had the opportunity, she would put on her mother's clothes out of the closet. Joy would gravitate to girls section when shopping for clothes.

133. Just before age 5, in 2018, the family moved to NC, where there was an accepting preschool at which Joy used she/her pronouns, wore girls' clothes, and used the girls' bathroom.

134. The following year, Joy began attending an affirming elementary school as a girl. Her teachers are supportive, and she is known as a girl by her peers. She enjoys cooking and making jewelry.

135. Joy's parents report a series of discussions with pediatric endocrinologist Dr. Jain which included the risks and benefits of puberty blockers. Joy had observed her older brothers and expressed that she didn't want to grow a beard or moustache and didn't want her voice growing deeper.

136. In December 2023, Joy's healthcare providers noted the start of Tanner Stage 2. Joy has needed more privacy, and is more self-aware of her body and its development. Joy has had a growth spurt and has desired treatment to halt puberty.

137. Joy's parents note that "Joy knows herself" and her gender identity. She is not misgendered and "lives her life like any other girl." She plays lacrosse and swims. She feels "truly accepted" by her family, her peers, and her community. She fears this could change with puberty.

138. Joy was referred to Dr. Reynolds at Carilion Clinic Roanoke Pediatric Endocrinology to initiate gender affirming medical care.

139. On April 30, 2024, Joy received her first Lupron Depot 6-month injection in Virginia. Her parents spent January to April working to get the AbbVie patient assistance program to pay for the first injection, but had to pay the expenses of travel, hotel, and time off, which was a hardship for them.

140. The family must reapply annually for AbbVie patient assistance.

141. Joy's parents report that Joy had mental health assessments at both Duke and UNC prior to treatment. They report discussions with Joy's healthcare providers on risks and benefits of puberty blockers, including bone health and if she continues with medical transition, reproduction. Joy's parents report having discussions with Joy on different means of having a family.

142. There is no history of psychiatric medications or other treatment. Joy's parents report that Joy has some social anxiety, a symptom she shares with her brothers.

143. On exam, Joy is responsive to questioning but in an age-appropriate way, looks to her mother to fill in details. There is no evidence of psychiatric symptoms. Joy has the capacity to assent to treatment, with an understanding of the purpose of treatment, the potential of side effects, and future consequences. Her parents have a good understanding of risks and benefits of treatment and have capacity to consent to treatment for Joy.

144. Joy Doe is a 10-year-old transgender girl at Tanner Stage 2. She has a diagnosis of Gender Dysphoria in Adolescents and Adults. Joy meets WPATH Standards of Care Version 8 criteria for puberty blockers, which are a medically necessary treatment for her Gender Dysphoria.

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V. CONCLUSION

145. The accepted protocols for the treatment of transgender adolescents with gender dysphoria provide for mental health assessments, including of co-occurring conditions; criteria for eligibility for each treatment; and an informed consent process before medical interventions are initiated.

146. The Ban prohibits widely accepted, evidence-based medical treatments for gender dysphoria in adolescents. The Ban prohibits the only treatments demonstrated to be effective for adolescents with gender dysphoria for whom gender-affirming medical care is indicated.

147. Decades of medical research and clinical experience demonstrate that these medical treatments are safe, effective, and medically necessary to relieve gender dysphoria for many adolescents.

148. Consistent with my first-hand clinical experience over decades of practice, denying gender-affirming medical care to adolescents for whom it is medically indicated puts them at risk of significant harm to their health and well-being, including heightened risk of depression and suicidality.

* * *

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 1st day of June 2024.

Dan H. Karasic, M.D.

Exhibit A

University of California, San Francisco

CURRICULUM VITAE

Name: Dan H. Karasic, MD

Position: Professor Emeritus
Psychiatry
School of Medicine

Voice: 415-935-1511

Fax: 888-232-9336

EDUCATION

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990	Medical Licensure, California, License Number G65105
1990	Drug Enforcement Administration Registration Number BK1765354
1993	American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clincial Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical Professor

1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry Associate Clinical Professor
2005 - 2020	University of California, San Francisco	Health Sciences Psychiatry Clinical Professor
2020-present	University of California, San Francisco	Professor Emeritus of Psychiatry

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; UCLA Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatrist	Psychiatry
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San Francisco General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)	Clinical Director	Psychiatry and Medicine
2003 - 2020	Transgender Life Care Program and Clinic, Castro Mission Health	Psychiatrist Dimensions Clinic	Dimensions Center
2013 - 2020	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa
1990	NIMH Postdoctoral Fellowship in Health Services for People with AIDS (1990-1991)	National Institute of Mental Health Mental
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF
2023	Alumni Seal Award for Achievement	Occidental College Professional

MEMBERSHIPS

1992 - present Northern California Psychiatric Society

1992 - present American Psychiatric Association

2000 - 2019 Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)

2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

1981 - 1982	The Occidental	News Editor
1984 - 1985	Yale University School of Medicine	Class President
1989 - 1991	Kaposi's Sarcoma Group, AIDS Project Los Angeles	Volunteer Facilitator
1992 - 1996	Early Career Psychiatrist Committee, Association of Gay Lesbian Psychiatrists	Chair and
1992 - 1996	Board of Directors, Association of Gay and Lesbian	Member Psychiatrists
1993 - 1993	Local Arrangements Committee, Association of Gay and Psychiatrists	Chair Lesbian
1994 - 1995	Educational Program, Association of Gay and Lesbian 1995 Annual Meeting	Director Psychiatrists,
1994 - 1998	Board of Directors, BAY Positives	Member
1994 - 2020	Committee on Lesbian, Gay, Bisexual and Transgender	Member

Issues, Northern California Psychiatric Society

1995 - 1997 Board of Directors, Bay Area Young Positives. BAY Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth — President

1995 - 1997 Executive Committee, Bay Area Young Positives. — Chair

1996 - 2004 Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society — Chair

1998 - 2002 City of San Francisco Human Rights Commission, Gay Bisexual Transgender Advisory Committee — Member Lesbian,

2000 - 2004 Association of Gay and Lesbian Psychiatrists. the organization's educational programs — Vice President Responsible for

2004 - 2005 Association of Gay and Lesbian Psychiatrists — President-elect

2005 - 2007 Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the American Psychiatric Association — Chair

2005 - 2007 Association of Gay and Lesbian Psychiatrists — President

2007 - 2009 Association of Gay and Lesbian Psychiatrists — Immediate Past President

2009 - 2010 Consensus Committee for Revision of the Sexual and Gender Identity Disorders for DSM-V, GID of Adults subcommittee. (Wrote WPATH recommendations as advisory body to the APA DSM V Committee for the Sexual and Gender Identity Disorders chapter revision.) — Member

2010 - 2011 Scientific Committee, 2011 WPATH Biennial Symposium, Atlanta — Member

2010 -2022 World Professional Association for Transgender Care Standards of Care Workgroup and Committee (writing seventh and eighth revisions of the WPATH Standards of Care, which is used internationally for transgender care.) — Member

2010 - 2018 ICD 11 Advisory Committee, World Professional Association for Transgender Health — Member

2012 - 2014 Psychiatry and Diagnosis Track Co-chair, Scientific 2014 WPATH Biennial Symposium, Bangkok — Member Committee,

2014 - 2016 Scientific Committee, 2016 WPATH Biennial Symposium, Amsterdam — Member

2014 - 2018 Board of Directors (elected to 4 year term), World Association for Transgender Health — Member Professional

2014 - 2018 Public Policy Committee, World Professional Association for Transgender Health — Chair

2014 - 2018 WPATH Global Education Initiative: Training providers and specialty certification in transgender health — Trainer and Steering

		Committee Member
2014 - 2016	American Psychiatric Association Workgroup on Gender Dysphoria	Member
2016 - present	American Psychiatric Association Workgroup on Gender Dysphoria	Chair
2016	USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017	Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

2011 - present Journal of Sexual Medicine, reviewer

2014 - present International Journal of Transgenderism, reviewer

2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009	World Professional Association for Transgender Health, Oslo, Norway	Plenary Session Speaker
2009	World Professional Association for Transgender Health, Oslo, Norway	Symposium Speaker
2009	Karolinska Institutet, Stockholm Sweden	Invited Lecturer
2012	Cuban National Center for Sex Education (CENESEX), Havana, Cuba	Invited Speaker
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China	Expert Consultant
2014	World Professional Association for Transgender Health, Thailand	Track Chair Bangkok,
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Symposium Chair
2015	Israeli Center for Human Sexuality and Gender Identity,	Invited Speaker Tel Aviv
2016	World Professional Association for Transgender Health, Amsterdam	Symposium Chair
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker

2016 World Professional Association for Transgender Health, Amsterdam 2017 Brazil Professional Association for Transgender Health, Sao Paulo — Invited Speaker

2017 Vietnam- United Nations Development Programme Asia Transgender Health Conference, Hanoi

2018 United Nations Development Programme Asia Conference on Transgender Health and Human Rights, Bangkok

2018 World Professional Association for Transgender Health, Invited Speaker Buenos Aires

2021 Manitoba Psychiatric Association, Keynote Speaker

2022 World Professional Association for Public Health, invited speaker, Montreal

INVITED PRESENTATIONS - NATIONAL

1990 Being Alive Medical Update, Century Cable Television — Televised Lecturer

1992 Institute on Hospital and Community Psychiatry, Toronto — Symposium Speaker

1992 Academy of Psychosomatic Medicine Annual Meeting, San Diego — Symposium Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia — Workshop Chair

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia — Workshop Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia — Paper Session Co-chair

1995 Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach — Symposium Chair

1996 American Psychiatric Association 152nd Annual Meeting, New York — Workshop Speaker

1997 American Psychiatric Association Annual Meeting, San Diego — Workshop Speaker

1997 Gay and Lesbian Medical Association Annual — Invited Speaker Symposium

1998 American Psychiatric Association Annual Meeting, Toronto — Workshop Chair

1998 American Psychiatric Association Annual Meeting, Toronto — Workshop Chair

1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists Chair Symposium, New Orleans	
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME	Chair Conference
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co-Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair
2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker

2004	Association of Gay and Lesbian Psychiatrists Conference, New York	Co-Chair
2004	Mental Health Care Provider Education Program: Los Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	Invited Speaker
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial

Invited Speaker

2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles Course Faculty	
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

2017 American Urological Association Annual Meeting, San Francisco CA Invited Speaker

2018 World Professional Association for Transgender Health GEI, Portland OR, Course Faculty

2018 World Professional Association for Transgender Health GEI, Palm Springs, Course Faculty

2019 American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker

2019 American Psychiatric Association Annual Meeting, San Francisco, Session Chair

2020 Psychiatric Congress, Invited Speaker

2022 World Professional Association for Transgender Health, Montreal, invited speaker

2023 National Transgender Health Summit, San Francisco, invited speaker

2023 American Psychiatric Association Annual Meeting, San Francisco, invited speaker

2023` US Professional Association for Transgender Health, speaker

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1990	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Symposium Speaker
1991	Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine	Workshop Panelist
1992	Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute	Invited Lecturer
1993	UCSF School of Nursing	Invited Lecturer
1995	UCSF/SFGH Department of Medicine Clinical Care Conference	Invited Speaker
1996	UCSF School of Nursing	Invited Speaker

		Invited Speaker
1996	Psychopharmacology for the Primary Care AIDS/Clinician, series of four lectures, UCSF Department of Medicine	Invited Lecturer
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langley Porter Psychiatric Hospital and Clinics	Invited Speaker Grand Rounds
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	Northern California Psychiatric Society LGBT Committee	Chair Fall Symposium
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Rosa	Invited Speaker Santa
1999	Northern California Psychiatric Society Annual Meeting, Rosa	Invited Speaker Santa
1999	University of California, Davis, Department of Psychiatry Rounds	Invited Speaker Grand
1999	California Pacific Medical Center Department of Grand Rounds	Invited Speaker Psychiatry
1999	San Francisco General Hospital Department of Psychiatry Departmental Case Conference	Discussant
2000	Langley Porter Psychiatric Hospital and Clinics Consultation Liaison Seminar	Invited Speaker
2000	San Francisco General Hospital, Psychopharmacology Seminar	Invited Speaker

2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker
2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker
2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender Prevention and Care, San Francisco	Invited Speaker HIV
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health San Francisco LGBT Community Center	Invited Speaker Symposium,
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker

Invited Speaker

2012 UCSF AIDS Health Project Invited Speaker 2012 San Francisco Veterans Affairs Medical Center.

2013 Association of Family and Conciliation Courts Conference, Invited Speaker Los Angeles, CA

2014 UCSF Transgender Health elective Invited Speaker

2014 UCSF Department of Psychiatry Grand Rounds Invited Speaker

2014 California Pacific Medical Center Department of Invited Speaker Psychaitry Grand Rounds

2014 UCLA Semel Institute Department of Psychiatry Grand Invited Speaker Rounds

2015 UCSF Transgender Health elective Invited Speaker

2015 Fenway Health Center Boston, MA (webinar) Invited Speaker

2015 Transgender Health Symposium, Palm Springs Invited Speaker

2015 Transgender Health Symposium, Palm Springs Co-Chair

2015 Santa Clara Valley Medical Center Grand Rounds Invited Speaker

2016 UCSF School of Medicine Transgender Health elective Invited Speaker

2016 Langley Porter Psychiatric Institute APC Case Conference Invited Speaker (2 session series)

2016 Zuckerberg San Francisco General Department of Psychiatry Grand Rounds Invited Speaker

2016 UCSF Mini-Medical School Lectures to the Public Invited Speaker

2021 Los Angeles County Department of Mental Health, Invited Speaker

2023 Alameda County Department of Behavioral Health, Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005 Northern California Psychiatric Society

2005 Northern California Psychiatric Society Annual Meeting, Napa

2005 Association of Gay and Lesbian Psychiatrist Annual Conference

2006 Annual Meeting, American Psychiatric Association, Atlanta

2006 Annual Meeting, American Psychiatric Association, Toronto

2006 Institute on Psychiatric Services, New York

2007 Association of Gay and Lesbian Psychiatrists Annual Conference

2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco
2009	American Psychiatric Association, San Francisco
2009	World Professional Association for Transgender Health, Oslo, Norway
2010	Annual Meeting of the Northern California Psychiatric Society, Monterey, CA
2011	Transgender Mental Health Care Across the Life Span, Stanford University
2011	National Transgender Health Summit, San Francisco
2011	American Psychiatric Association Annual Meeting, Honolulu, HI
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA
2011	Institute on Psychiatric Services, San Francisco
2012	Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013	National Transgender Health Summit, Oakland, CA
2013	American Psychiatric Association Annual Meeting, San Francisco
2013	Gay and Lesbian Medical Association, Denver, CO
2014	American Psychiatric Association Annual Meeting, New York
2014	Institute on Psychiatric Services, San Francisco
2015	European Professional Association for Transgender Health, Ghent, Belgium
2015	National Transgender Health Summit, Oakland
2015	American Psychiatric Association Annual Meeting, Toronto
2016	American Psychiatric Association Annual Meeting, Atlanta
2016	World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002	City and County of San Francisco Human Rights Member Commission LGBT Advisory Committee

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course fort the 2015 and 2016 APA Annual Meetings, and has an larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I have been active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8.
I chaired of the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 2000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 – 2003 HIV/AIDS Task Force Member

1992 - 1993 HIV Research Group Member

1992 - 1997	Space Committee	Member
1992 - 2003	Gay, Lesbian and Bisexual Issues Task Force	Member
1994 - 1997	SFGH Residency Training Committee	Member
1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair
1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual
1996 - 2003	HIV/AIDS Task Force	Co-Chair
1996 - 2003	Cultural Competence and Diversity Program	Member
2009 - present	Medical Advisory Board, UCSF Center of Excellence for Transgender Health	Member
2010 - 2013	Steering Committee, Child Adolescent Gender Center	Member
2011 – 2017	Mental Health Track, National Transgender Health Summit	Chair

DEPARTMENTAL SERVICE

1991 - 2003 San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force

1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group

1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee

1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force

1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee

1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program

1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force

2012 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee

2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force

2014 - 2020San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. Diabetes. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. Journal of Neural Transmission. General Section, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. Psychosomatics. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. The Northern California Psychiatric Physician. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. Focus. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association. 1997 1(1) 41-47.

7. Karasic DH. Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 4(4) 2000 157-8.

8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. Focus: A Guide to AIDS Research and Counseling. 2002 17(9) 5-6.

9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. International Journal of Transgenderism. Volume 12, Issue 2. 2010, Pages 80-85.

10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. International Journal of Transgenderism, 13:165-232, 2011

11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. American Journal of Public Health. February 2013, Vol. 103, No. 2, pp. 308-315.

12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. AIDS and Behavior, October 2013, Volume 17, Issue 8, pp 2765-2772.

13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. LGBT Health. 2016 Aug; 3(4):245-7. PMID: 27458863

14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. Lancet. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925

15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. AIDS Care. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273

16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kuschner ES, Mandel F, Caretto A, Lewis HC, Anthony LG.
Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. J Clin Child Adolesc Psychol. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428

17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. J Sex Med 2017;14:624–634.

18. William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F.L. Meyer-Bahlburg, Richard R. Pleak, and Jack Pula.Gender Dysphoria in Adults:

An Overview and Primer for Psychiatrists.Transgender Health.Dec 2018.57-A3.http://doi.org/10.1089/trgh.2017.0053

19. Identity recognition statement of the world professional association for transgender health (WPATH). International Journal of Transgenderism. 2018 Jul 3; 19(3):1-2. Knudson KG, Green GJ, Tangpricha TV, Ettner ER, Bouman BW, Adrian AT, Allen AL, De Cuypere DG, Fraser FL, Hansen HT, **Karasic KD**, Kreukels KB, Rachlin RK, Schechter SL, Winter WS, Committee and Board of Direct

20. **Karasic, DH** & Fraser, L Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue, Vol 45, Issue 3, pp 295-299. 2018 Elsevier,Philadelphia**.** https://doi.org/10.1016/j.cps.2018.03.016

21. Milrod C, Monto M, **Karasic DH.** Recommending or Rejecting "the Dimple": WPATHAffiliated Medical Professionals' Experiences and Attitudes Toward GenderConfirming Vulvoplasty in Transgender Women. J Sex Med. 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.

22. ICD-11 and gender incongruence of childhood: a rethink is needed. Lancet Child Adolesc Health. 2019 10; 3(10):671-673. Winter S, Ehrensaft D, Telfer M, T'Sjoen G, Koh J, Pickstone-Taylor S, Kruger A, Griffin L, Foigel M, De Cuypere G, **Karasic D**. PMID: 31439494.

23. Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists. Focus (Am Psychiatr Publ). 2020 Jul; 18(3):336-350. Byne W, **Karasic DH**, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HFL, Pleak RR, Pula J. PMID: 33343244; PMCID: PMC7587914.

24. WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, **D. H. Karasic**… J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

BOOKS AND CHAPTERS

1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.

2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: The AIDS Knowledge Base, Third Edition. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams &Wilkens, Philadelphia, 1999, pp. 577-584.

3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH.** The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D.** We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html

2014 Cabading v California Baptist University

2014 CF v. Alberta
http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- 2018 Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan
https://canliiconnects.org/en/summaries/54130
https://canliiconnects.org/en/cases/2018skqb159

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

2021 Expert, Kadel v. Folwell, 1:19-cv-00272 (M.D.N.C.).

2021 Expert, Drew Glass v. City of Forest Park - Case No. 1:20-cv-914 (Southern District Ohio)

2021-2022 Expert, Brandt et al v. Rutledge et al. 4:21-cv-00450 (E.D. Ark.)

2021-2022 Expert, Fain v. Crouch, 3:20-cv-00740 (S.D.W. Va.)

2022 Expert, C.P. v. Blue Cross Blue Shield of Illinois, No. 3:20-cv-06145-RJB (W.D. Wash.)

2022-3 Expert, Dekker, et al. v. Weida, et al., No. 4:22-cv-00325-RH-MAF

2019-2023 Expert, Disability Rights Washington v Washington State Department of Corrections

2023 Expert, K.C. et al. v Individual Members of the Indiana Licensing Board, et al- No. 1:23-CV-595

2023 Expert, Doe, et al v Ladapo -No. 4:23-cv-00114-RH-MAF

2023 Expert, Doe et al v Thornbury -No. 3:23-cv-00230-DJH

2023 Expert Voe v Mansfield

Exhibit B

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Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology, 7*(3), 302–311.

Almazan, A. N., & Keuroghlian, A. S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA surgery*, 156(7), 611–618.

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American Academy of Family Physicians (2020). Care for the Transgender and Nonbinary Patient, www.aafp.org/about/policies/all/transgender-nonbinary.html.

American Academy of Pediatrics (2018). Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents, https://pediatrics.aappublications.org/content/142/4/e20182162.

American College of Obstetricians and Gynecologists (2021). Committee Opinion No. 823: Health Care for Transgender and Gender Diverse Individuals, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals.

American Medical Association. (2023). AMA Resolution: Clarification of Evidence-Based Gender-Affirming Care. https://policysearch.ama-assn.org/policyfinder/detail/gender%20affirming%20care?uri=%2FAMADoc%2FHOD-185.927.xml

American Medical Association (2021). Letter to National Governor's Association , https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf.

American Medical Association and GLMA (2019). Issue Brief: Health insurance coverage for gender-affirming care of transgender patients, https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf.

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. (2020). Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth. https://www.psychiatry.org/getattachment/8665a2f2-0b73-4477-8f60-79015ba9f815/Position-Treatment-of-Transgender-Gender-Diverse-Youth.pdf

American Psychiatric Association (2018). Position Statement on Access to Care for Transgender and Gender Diverse Individuals, https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf.

American Psychological Association. (2024). APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science. https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care.pdf

American Psychological Association (2021). APA Resolution on Gender Identity Change Efforts, https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf. American Psychological Association (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, 70, 832-864.

Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone therapy, mental health, and quality of life among transgender people: A systematic review. *Journal of the Endocrine Society*, 5(4), 1-16.

Barrett D., Heale R. (2020). What are Delphi studies? *Evidence-Based Nursing*, 23:68-69.

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC public health*, *15*, 525.

Brik, T., Vrouenraets, L. J. J. J., de Vries, M. C., & Hannema, S. E. (2020). Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria. *Archives of sexual behavior*, *49*(7), 2611–2618.

Bruce, L., Khouri, A. N., Bolze, A., Ibarra, M., Richards, B., Khalatbari, S., Blasdel, G., Hamill, J. B., Hsu, J. J., Wilkins, E. G., Morrison, S. D., & Lane, M. (2023). Long-Term Regret and Satisfaction With Decision Following Gender-Affirming Mastectomy. *JAMA*

surgery, e233352. Advance online publication. https://doi.org/10.1001/jamasurg.2023.3352

Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and reconstructive surgery. Global open*, *9*(3), e3477.

Byne, W., Karasic, D. H., Coleman, E., Eyler, A. E., Kidd, J. D., Meyer-Bahlburg, H. F. L., … Pula, J. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health*, *3*(1), 57-70.

Cavve, B. S., Bickendorf, X., Ball, J., Saunders, L. A., Thomas, C. S., Strauss, P., Chaplyn, G., Marion, L., Siafarikas, A., Ganti, U., Wiggins, A., Lin, A., & Moore, J. K. (2024). Reidentification With Birth-Registered Sex in a Western Australian Pediatric Gender Clinic Cohort. *JAMA pediatrics*, *178*(5), 446–453.

Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Med.* 2023 Jan 19;388(3):240-250.

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